CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 530

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: APRIL 22, 2005

Change Request 3800

THIS CR IS A FULL REPLACEMENT FOR THE TRANSMITTAL 465, CR 3559, ISSUED FEBRUARY 4, 2005. CHANGE REQUEST 3559 IS RECINDED

SUBJECT: Billing Requirements for Physician Services Rendered in Method II Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: This transmittal: 1) Establishes a mechanism that will prevent the overpayment of physician services rendered in a Method II CAH; 2) Corrects the type of bill (TOB) for CAH outpatient to 85x (the TOB was stated as 72x in Change Request 3262, Transmittal 262, dated July 30, 2004); 3) Clarifies the non-applicability of the payment window provisions; 4) Includes the new file layout for the 2005, Physician Fee Schedule Supplemental file; and 5) Establishes a mechanism for a CAH, using the Method II payment methodology, with off-site outpatient departments/clinics to receive HPSA/PSA bonus payments if applicable.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : 01/05/04 - HPSA Bonus; 01/03/05 - Physician Scarcity; 07/01/01 - Physician Services

IMPLEMENTATION DATE : July 05, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	3/30/30.1.1/Payment for Inpatient Services Furnished by a CAH
R	4/250/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

R	4/250/250.2.1/Billing and Payment in a Physician Scarcity Area (PSA)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 530	Date: April 22, 2005	Change Request 3800

SUBJECT: Billing Requirements for Physician Services in Method II Critical Access Hospitals (CAHs) – Replacement for Change Request (CR) 3559

I. GENERAL INFORMATION

A. Background: The correct type of bill (TOB) for a CAH for outpatient services is 85x. In CR 3262, Transmittal 262, dated July 30, 2004, TOB 72x was stated in error.

Clarification on CAHs being exempt from the payment window provisions is included in the attached manual instructions.

Payment for some physician services submitted by CAHs utilizing Method II billing is being paid incorrectly. This is occurring because intermediaries are making payments based on the supplemental file, which has contained only non-facility fee schedule amounts until now. Under Method II, physician services are paid to the CAH at 115% of the applicable Medicare Physician Fee Schedule (MPFS) payment amount. Payment should be based on the MPFS facility rate for the applicable HCPCS codes. FIs have been incorrectly paying the MPFS non-facility rate, since that was the only rate they had received. This instruction includes guidelines for paying the correct MPFS facility rate.

The MMA established an additional 5% payment for services rendered in a Physician Scarcity Area (PSA), and required the automation of the Health Professional Shortage Area (HPSA) incentive payment. CAHs can have outpatient departments/clinics that are off-site, not physically located in the hospital. Presently, there is no way to differentiate the offsite outpatient department/clinic bill from the CAH bill; therefore, no bonus payments are being made for services rendered in the off-site outpatient department/clinic if located off-site from the CAH. For example: 1) If a CAH is not located in a bonus area and the off-site outpatient department/clinic is located in a bonus area, the physician bonus is payable for services rendered in the off-site outpatient department; or 2) If the CAH is in a bonus area, but the physician service is rendered at the off-site outpatient department/clinic which is not located in a bonus area, a bonus payment will not be paid.

B. Policy: Physician services that are rendered in a CAH facility, billing under Method II, should be paid using the appropriate facility fee schedule amount from the Medicare Physician Fee Schedule.

To identify off-site outpatient departments/clinics of CAHs, that elected Method II payment methodology, the site of service address including zip code, must be on the claim.

The policy for bonus payments is consistent with instructions in CR 3262.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3800.1	The FI/FISS shall load the facility rate for each HCPCS.	X				X				
3800.2	The FI/FISS shall use the established Medicare Physician Fee Schedule (MPFS) supplemental file, to pay the professional component when appropriate.	X				X				
3800.2.1	The FI/FISS shall use the new Record Layout for the CORF Services Supplemental Fee/Schedule Critical Access Hospital Fee Schedule.	X				X				
3800.3	The FI/FISS shall pay the facility fee amount for the HCPCS code for the physician service rendered, to a CAH under the method II payment methodology.	X				X				
3800.4	The FIs shall inform their CAHs, that elect Method II payment methodology, to submit the zip codes of their off-site outpatient departments to the respective FIs.	X								
3800.4.1	The FISS shall create (maximum of 5 iterations) fields in the provider file to carry the zip codes, and indicators, for off-site outpatient departments..					X				
3800.5	The FIs shall inform their CAHs that the off-site outpatient department/clinic's address, including zip code, should be placed in the 2310E loop of the 837I for electronic claims. For billing on a hard copy UB-92 and DDE, the service address should be placed in the "Remarks." However, the zip code placement for DDE and hardcopy will be determined by the FI.	X				X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3800.6	The FISS shall read loop 2310E of the 837I for CAH claims when Method II has been selected.					X				
3800.7	The FISS must look at the service facility zip code to determine if a bonus payment is due for professional services. This applies to both the HPSA bonus and the PSA bonus.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3800.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Physician Services-July 1, 2001 HPSA Bonus-January 5, 2004 Physician Scarcity-January 3, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Doris Barham – 410-786-6146; Pat Barrett - 410-786-0508 **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101 percent of the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply*:*

- The lesser of costs or charges (LCC) rule;
- Ceilings on hospital operating costs;
- The reasonable compensation equivalent (RCE) limits for physician services to hospitals; and
- The payment window provisions for preadmission services treated as inpatient services under §40.3. *(Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who is an outpatient prior to that beneficiary's admission to the CAH as an inpatient, are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill (85x TOB) from inpatient services. CWF and the shared system shall bypass the CAH provider numbers when applying the edits that compare hospital outpatient and inpatient bills to apply the window provisions. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.)*

Low Osmolar Contrast Material (LOCM) furnished as part of medically necessary imaging procedures for inpatients is paid for based on bill type 11X (for LOCM furnished during an inpatient stay covered under Part A), or 12X(for LOCM furnished to an inpatient where payment is under Part B because the stay is not covered under Part A). Bills must include revenue code 636 along with one of the following HCPCS codes as appropriate:

A4644	Supply of low osmolar contrast material (100 – 199 mgs of iodine);
A4645	Supply of low osmolar contrast material (200 – 299 mgs of iodine); or
A4646	Supply of low osmolar contrast material (300 – 399 mgs of iodine).

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirements. Inpatient services should be billed on an 11X type of bill.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in affect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS 855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of the 855R to the intermediary, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the Form CMS-1450 (or electronic equivalent), list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI will pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus:
- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

- The FI uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The data in the supplemental file will be in the same format as the abstract file. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for nonphysician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

  For a non-participating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for non-participating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925. To calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925.

  Payment for non-physician practitioners will be 115 percent of the allowable amount under the physician fee schedule.

  If a non-physician practitioner renders a service, one of the following modifiers must be on the applicable line:

  GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.)

  SB - Services rendered in a CAH by a nurse midwife.

  AH - Services rendered in a CAH by a clinical psychologist.

  AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Referenced diagnostic services (non-patients) are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. *If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.*

CORF SERVICES SUPPLEMENTAL FEE SCHEDULE
CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

DATA SET NAMES: MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI

This is the final physician fee schedule supplemental file.

RECORD LENGTH: *60*
RECORD FORMAT: *FB*
BLOCK SIZE: *6000*
CHARACTER CODE: *EBCDIC*
SORT SEQUENCE: *Carrier, Locality HCPCS Code, Modifier*

Data Element Name	*Location*	*Picture*	*Value*
1 - HCPCS	*1-5*	*X(05)*	
2 - Modifier	*6-7*	*X(02)*	
3 - Filler	*8-9*	*X(02)*	
4 - Non-Facility Fee	*10-16*	*9(05)V99*	
5 - Filler	*17-17*	*X(01)*	
6 - PCTC Indicator	*18-18*	*X(01)*	*This field is only applicable when pricing Critical Access Hospitals (CAHs) that have Elected the optional method (Method 2) of payment.*
7 - Filler	*19*	*X(1)*	
8 - Facility Fee	*20-26*	*9(05)V99*	
9 - Filler	*27-30*	*X(4)*	
10 - Carrier Number	*31-35*	*X(05)*	
11 - Locality	*36-37*	*X(02)*	
12 - Filler	*38-40*	*X(03)*	
13 - Fee Indicator	*41-41*	*X(1)*	*Field not populated—filled with spaces.*
14 - Outpatient Hospital	*42-42*	*X(1)*	*Field not populated—Filled with spaces.*
15 - Status Code	*43-43*	*X(1)*	*Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered.*
14 - Filler	*44-60*	*X(17)*	

If a non-physician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned to the provider.**

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is

received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

250.2.1 - Billing and Payment in a Physician Scarcity Area (PSA)

(Rev. 530, Issued: 04-22-05; Effective: 01-05-04 - HPSA Bonus; 01-03-05 - Physician Scarcity; 07-01-01; Implementation: 07-05-05)

Section 413a of the MMA 2003 requires that a new 5 percent bonus payment be established for physicians in designated physician scarcity areas. The payment should be made on a quarterly basis and placed on the quarterly report that is now being produced for the HPSA bonus payments.

Section 1861(r)(1), of the Act, defines physicians as doctors of medicine or osteopathy. Therefore, dentists, chiropractors, podiatrists, and optometrists are not eligible for the physician scarcity bonus as either primary care or specialty physicians. Only the primary care designations of general practice, family practice, internal medicine, and obstetrics/gynecology, will be paid the bonus for the zip codes designated as primary care scarcity areas. All physician provider specialties are eligible for the specialty physician scarcity bonus except the following: oral surgery (dentist only); chiropractic; optometry; and podiatry. The bonus is to be paid based on date of service.

One of the following modifier(s) must accompany the HCPCS code to indicate type of physician:

AG – Primary Physician

AF – Specialty Physician

There may be situations when a CAH is not located in a bonus area but its outpatient department is in a designated bonus area, or vice versa. If a CAH has an off-sit outpatient department/clinic the off-site department's complete address, including the zip code, must be placed on the claim as the service facility. The FISS must look at the service facility zip code to determine if a bonus payment is due.

For electronic claims, the service facility address should be in the 2310E loop of the 837I. On the hard copy UB-92, the address should be placed in "Remarks"; however, the zip code placement will be determined by the FI.